Arkansas State Employees

Guide To Healthcare Choices

Open Enrollment Period:
October 1, 2002 - October 31, 2002

Changes and Enrollments Effective:
January 1, 2003 - December 31, 2003

Employee Benefits Division
Phone number: 501-682-9656
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STATE OF ARKANSAS
Department of Arkansas and Administration

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October 1, 2002

This Guide to Healthcare Choices is provided to help you understand your health care options for the upcoming new plan year and to help you select the option that is best for you. This booklet describes the health insurance plans available, benefits and their corresponding rates.

The month of October is the "Open Enrollment Period" for the eligible State employees/dependents group health insurance program. This is when you are provided information regarding your health insurance for the new plan year through your agency insurance representative. The new plan year starts on January 1, 2003. During the open enrollment period, you may make changes in your plan, add or remove a family member from your plan and even change plans.

If you do not have any changes to make in your health plan, then no action is required on your part during the open enrollment. Please keep the Guide to Healthcare Choices booklet to reference benefits and contact information throughout the plan year.

If you do want to change insurance carriers or who is covered under your plan, contact your agency insurance representative in order to obtain the appropriate form. Change forms and enrollment forms can also be printed from our website, www.accessarkansas.org/dfa/ebd. Please return completed forms to your agency insurance representative for processing. **Retirees please return the completed forms to Employee Benefits Division.**

Sharon Dickerson, Executive Director

Sharon Dickerson

Employee Benefits Division

Your Health Care Guide

Overview

The material in this guide should make your health care options more understandable, but the information herein is not a contract. Please review this guide before making an enrollment decision. This *Guide to Healthcare Choices* does not and cannot describe every medical/behavioral contingency, or plan provision.

Enrollment

Enrollment for the 2003 plan year is characterized as a "passive enrollment." A passive enrollment means you do not have to complete an enrollment form unless you are a new employee or you want to choose a new health insurance plan or, are making a change on your current policy. All employees/dependents who are not covered by a State employee health insurance plan may enroll during the "open enrollment –October 2002", enrollment period.

You or your dependents cannot be added at any other time during the year unless you meet one of the following descriptions:

- You or your eligible dependents have lost other health insurance coverage through no action of your own or after the employer providing such other health plan terminated its contribution.
- You have acquired a new eligible dependent through marriage, birth, adoption or placement for adoption.

It is YOUR RESPONSIBILITY to notify your agency insurance representative of any status change or event that could potentially affect your health insurance coverage. You must request enrollment for yourself or eligible dependents within 30 days after loss of coverage or acquisition of a new dependent. Your agency insurance representative will provide you with the enrollment form.

Important Dates

If you are an active employee, health insurance enrollment or change forms must be completed and returned to your agency insurance representative in October by the due dates they establish. If you are a retiree, health insurance forms must be completed and returned by mail to Employee Benefits Division, Retirement Section with a postmark no later than October 31, 2002. Elections made will take effect January 1, 2003. Enrollment and change forms will be sent to you under separate cover.

Offerings for this Plan Year

- 2 Health Maintenance Organizations (HMO) – Health Advantage and QualChoice/QCA
- 2 Point of Service (POS) – Health Advantage and QualChoice/QCA
- 1 Preferred Provider Organization (PPO) – Arkansas Blue Cross and Blue Shield
- Employee Assistance Plan / Mental Health- StarEAP offered through CorpHealth with participation in any of the above health plans.

PPO Facts (Preferred Provider Organization):

- Offers access to the largest network of hospitals, physicians, and other healthcare providers.
- Does not require members to have a Primary Care Physician.
- Offers wide range of comprehensive healthcare services.

HMO Facts (Health Maintenance Organization):

- Offers wide range of comprehensive healthcare services.
- Provides members with the lowest out-of-pocket expenses.
- Requires members to obtain referral from the Primary Care Physician to access healthcare from another provider or specialist.
- Provides no benefits to members outside the network. If your Primary Care Physician wishes you to seek services outside the network, he/she must first obtain a referral from the insurance company.

Remember if you select an HMO, always get a referral from your Primary Care Physician and stay in the network. There are no benefits outside the network of providers. It is your responsibility to call the insurance company, check the provider manual or look on-line to assure the providers are in the network.

POS Facts (Point of Service):

- Offers wide range of comprehensive healthcare services.
- Requires members to obtain referral from the Primary Care Physician to access healthcare from another provider or specialist in order to maximize the POS benefit.
- Members can access healthcare services without a referral from their Primary Care Physician and members can go out of network. The downside is that when going out of network or when not getting a Primary Care Physician referral, the benefits are subject to the out-of-network deductible and reimbursed at 70% of the maximum allowable amount and NOT the billed rate. Maximum allowable amounts are usually the amount that the insurance company would allow for services provided by their in-network providers. See example.

In summary, there are no benefits outside the pure HMO network and limited benefits outside the POS network except for emergency services and authorized referrals. The PPO is an indemnity plan.

Point of Service Out-of-Network (3-day stay)

Hospital billed charges	$6,000.00
Health Plan's allowable (3-day stay @ $800.00 per day)	$2,400.00
Difference (Member's responsibility)	$3,600.00

Health Plan's Financial Responsibility		**Member's Financial Responsibility**	
Health Plan's Allowable Charges	$2,400.00	Health Plan's Allowable Charges	$2,400.00
Less Member's Deductible	500.00	Less Member's Deductible	500.00
	$1,900.00		$1,900.00
Less Member's Coinsurance	570.00	Member's Coinsurance (30% of $1,900.00)	570.00
Health Plan's Financial Responsibility	**$1,330.00**		
		Difference between Billed and Allowed Charges	$3,600.00
		Member's Financial Responsibility	
		Deductible	$ 500.00
		Coinsurance	$ 570.00
		Difference	$ 3,600.00
		Total	**$ 4,670.00**
In this example, the Health Plan pays 22% of billed charges.*		**In this example the Member pays 78% of billed charges.***	

Note: Our health plans are contracted with providers and facilities. If a member accesses services out-of-network (non-contracted provider or facility) the member will be balance billed. Services must be deemed medically necessary by the health plan. If services are not deemed medically necessary, the member will be responsible for the total charges of those services.

In this same example if the member stays in the network the health plan pays $1,935.00 or 81% and the member pays $465.00 or 19%.

Contact List

HEALTH INSURANCE PROVIDERS

Arkansas Blue Cross & Blue Shield PPO /Indemnity Plan
P. O. Box 2181, Little Rock, AR 72203
In Little Rock: (501) 378-2437 / Outside Little Rock: (800) 482-8416
M-F 8:00 a.m. to 5:00 p.m.
E-mail: stateemployees@arkbluecross.com
Web site: www.arkbluecross.com

Health Advantage - POS
P. O. Box 8069, Little Rock, AR 72203
In Little Rock: (501) 378-2437/ Outside Little Rock: (800) 482-8416
M-F 8:00 a.m. to 5:00 p.m.
E-mail: stateemployees@arkbluecross.com
Web site: www.healthadvantage-hmo.com
10800 Financial Centre Parkway, Suite 540, Little Rock, AR 72211
In Little Rock: (501) 228-7111 / Outside Little Rock: (800) 235-7111
M-F 8:00 a.m. to 5:00 p.m.
Send e-mail inquiries by clicking on https://www.qcark.com/ContactUs/
Web site: www.qcark.com

Health Advantage - HMO
P. O. Box 8069, Little Rock, AR 72203
In Little Rock: (501) 378-2437/ Outside Little Rock: (800) 482-8416
M-F 8:00 a.m. to 5:00 p.m.
E-mail: stateemployees@arkbluecross.com
Web site: www.healthadvantage-hmo.com

QualChoice/QCA - HMO
10800 Financial Centre Parkway, Suite 540, Little Rock, AR 72211
In Little Rock: (501) 228-7111 / Outside Little Rock: (800) 235-7111
M-F 8:00 a.m. to 5:00 p.m.
Send e-mail inquiries by clicking on https://www.qcark.com/ContactUs/
Web site: www.qcark.com

MENTAL HEALTH, BEHAVIORAL HEALTH & SUBSTANCE ABUSE INSURANCE PROVIDER

CORPHEALTH/STAR EAP
1701 Centerview Dr., Suite 101, Little Rock, AR 72211
1-866-378-1645
M-Sun. 24 hours a day
Web site: www.corphealth.com

PRESCRIPTION BENEFIT

AdvancePCS
1300 E. Campbell, Richardson TX 75081
1-877-456-9586
M-F: 7:00 a.m. - 10:00 p.m. Sat.: 8:00 a.m. - 8:00 p.m.
Sun.: 8:00 a.m. - 4 p.m.
State of Arkansas custom web site: http://ar.advancerx.com
National web site: http://ar.buildingbetterhealth.com

COBRA

CompLink
500 North Akard, Suite 2250, Dallas, TX 75201
1-877-451-6272
M-F 8 a.m. - 6:00 p.m.
Web site: www.compliancelink.com

LIFE INSURANCE

USAble Life
320 W. Capitol, Suite 700, Little Rock, AR 72201
Little Rock: 375-7200 Outside Little Rock: 1-800-648-0271
M-F 8 a.m. - 4:30 p.m.
Web site: www.usablelife.com

MEMBER ADVOCATES & RETIREMENT ADVOCATES

Employee Benefits Division
1515 West 7th Street, Suite 300, Little Rock, AR 72201
Little Rock: 682-9656 Outside Little Rock: 1-877-815-1017
M-F 8 a.m. - 4:30 p.m.
E-mail: askebd@dfa.state.ar.us
Web site: www.accessarkansas.org/dfa/ebd/

Prescription Drug Program

Your prescription drug program is a stand-alone, self-insured plan, which is included with your group health insurance plan and administered by AdvancePCS. Benefits apply equally to all enrollees regardless of the health care plan you choose. If you are a new enrollee in the health plan, you will automatically receive a prescription drug card that offers you important savings on your prescribed medication

The copays for up to a 34-day supply of medicine, the copayment remains at:

- $10 for generic drugs
- $25 for "formulary" brand-name drugs
- $50 for "non-formulary" brand-name drugs

New! 4th Tier Benefit

Effective 10/01/02, a "Fourth Tier" benefit will be added to the previous three-tier pharmacy program. In addition to the Generic, Preferred Brand/Formulary, and Non-Formulary categories, Fourth Tier medications will now be available at the plan's discounted rate. Fourth Tier medications are medications that previously were not covered under this plan, such as weight loss medication, smoking cessation medication and treatments for hair loss. The plan will not pay any portion of the prescription, but you will be able to purchase the medication at the same discount the plan pays to pharmacies in our network. You will be responsible for the cost of the drug at the discounted rate. Purchases must be made at in-network pharmacies using your AdvancePCS ID card.

Selecting a Pharmacy

There are thousands of participating pharmacies nation-wide and most of your local pharmacies will honor your AdvancePCS prescription drug card. For more information about participating pharmacies including pharmacies in other states, contact AdvancePCS Customer Service at 1-877-456-9586.

Should you find it necessary to fill prescriptions at a non-participating pharmacy, the following procedure will be in place effective January 1, 2003:

- You must pay the entire cost of the prescription at the point of sale because the pharmacy does not recognize our co-pay structure.
- A paper claim must be completed and submitted to Advance PCS along with receipt from the purchase. That claim form can be obtained at the AdvancePCS website, http://ar.advancerx.com.

Note: The contracted price and the retail price are usually different; you will be responsible for that difference. They will also charge $1.25 for processing each claim. This charge had previously been paid by the plan but is now the member's responsibility.

- You will save money if you use a participating pharmacy when ever possible. A complete list is available at http://ar.advancerx.com or by calling AdvancePCS customer service at 1-877-456-9586.

Pilot Mail Order Pharmacy Program

A mail service prescription benefit was implemented on April 1, 2002. Most, but not all, long-term medications are available through AdvanceRX.com, including ostomy supplies, insulin and other diabetic supplies. Medications will be filled with a 90-day supply for the cost of 2 standard retail copays.

- Cost is two copays for a 90 days' supply of medication. The specific copay amount will be determined by whether the drug is generic, formulary or non-formulary and according to the current fee schedule.
- 2 X $10 = $20 for 90 day Generic supply
- 2 X $25 = $50 for 90 day Formulary/Preferred Brand Drug supply
- 2 X $50 = $100 for 90 day Non-Formulary/Non-Preferred Drug supply
- Only long-term or maintenance medications (3-month minimum prescription) will be eligible for mail order. Short runs of antibiotics or drugs that must be monitored are examples of medications that will not be filled through mail order.
- The mail order pharmacy program is voluntary. Members are also allowed to have prescriptions filled at their local pharmacy.
- New prescriptions must be filled twice at a local pharmacy before requesting mail order on that medication. Proof of two prior refills must be submitted with the initial request (i.e. pharmacy receipt, bottle labels, or a printout from your local pharmacy).

- Most mail order services are designed to substitute a generic drug for a name brand drug if one is available. Our new mail order plan will do the same because it is cost effective for the plan and for the participants. However, if a member cannot tolerate a generic drug, the doctor must clearly indicate that on the prescription slip and the request will be honored.
- The Exclusion List is on the website.

For more information about the mail service benefit or for a complete list of excluded drugs, please call AdvancePCS at 1-877-456-9586 or visit their website, http://ar.advancerx.com. Requests for mail order service should be submitted to: AdvanceRx.com, PO Box 830070, Birmingham, AL 35283-0070 on enrollment forms available from AdvancePCS, your agency insurance representative and the Employee Benefits Division.

Managing The Prescription Drug Program

Your prescription drug program is designed to provide the greatest benefit to the entire group of state and public school employees. This program requires: Prior Authorization of some medications; Quantity vs. Time (QVT) restrictions that are intended to clarify the usual quantity that constitutes a 34-day supply for particular medications; and Daily Dose Edits in order to eliminate inappropriate utilization of medications intended for once daily use. The Formulary is a dynamic entity that will change at least every three (3) months. As new drugs become available they may be added to the formulary and other drugs may be removed from the formulary, as generic drugs become available. Drugs may also be removed from the formulary and replaced by other drugs deemed to be more appropriate for our membership. For more information contact AdvancePCS toll-free at 1-877-456-9586.

Generic Drugs

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When you and your doctor authorize generic substitution, it permits the pharmacy to dispense a generic drug. This saves you and your pharmacy program money. Whenever possible, ask your doctor to prescribe generic drugs.

Other Benefits Your Prescription Drug Program Provides

Your prescription drug program offers other benefits for its members such as:

- Patient Support Program
- Disease State Management and its participating pharmacists
- "Specialty Rx" program to supply injectable medication and supplies (call 1-866-295-2779 for more information and to see if you or a family member qualifies).

AdvancePCS Web Site

A custom AdvancePCS website is now available for our members. The address is http://ar.advancerx.com. The web site offers many features including an interactive formulary listing, formulary updates, a national pharmacy locator and other member-oriented features. Members can also obtain information on the mail order pharmacy program at this site.

Life Insurance

Benefits

Active State employees who are benefits eligible will be automatically enrolled in $10,000 Basic Group Term Life and Accidental Death and Dismemberment (AD&D) coverage with USAble Life at no cost to the employee.

Supplemental Life Insurance

In addition to the Basic Group Term Life and AD&D, employees are eligible to participate in USAble Life's Supplemental Life and AD&D program. This program provides Supplemental Life Insurance benefits at either one or two times your annual salary, rounded up to the next $1,000 (coverage may not exceed $250,000; for Legislators/Constitutional Officers, coverage may not exceed $50,000). Rates for Supplemental Life coverage are listed in this section.

Dependent Life Insurance

Employees may elect up to $20,000 of ($40,000 for Legislators & Constitutional Officers) coverage on each of your eligible dependents. New employees can elect one unit ($4,000 for Active Employees or $20,000 for Legislators and Constitutional Officers) of Dependent Basic Life insurance only within 30 days of their hire date without answering medical questions. Employees who apply more than 30 days after their date of hire or elect additional units will be required to submit an application with medical questions completed. Coverage for dependents may not exceed 50% of employee's amount. Rates for Dependent Life coverage are listed in this section.

Enrollment

New and current employees may apply for Supplemental Life any time during the year. A life insurance application including the medical questions must be completed and submitted to USAble Life.

Employees do not have to be enrolled in health insurance to be eligible to enroll in the Supplemental Life insurance.

Please contact your agency representative to obtain a Supplemental Life application, or log onto EBD's website at:
www.accessarkansas.org/dfa/ebd
and download an application.

Basic life and Accidental Death and Dismemberment insurance is provided at no charge to employees. Supplemental life and Dependent life insurance rates are below.

Supplemental Age Category	Life Rates Monthly Rate per $1,000
less than 25	0.12
25-29	0.12
30-34	0.16
35-39	0.16
40-44	0.24
45-49	0.38
50-54	0.60
55-59	0.86
60-64	1.28
65-69	2.46
70-74	3.98
75-79	7.88
80+	12.80

Dependent Life Insurance Rates

1	Unit	=	$4,000	$2.16	/ month
2	Units	=	$8,000	$4.32	/ month
3	Units	=	$12,000	$6.48	/ month
4	Units	=	$16,000	$8.64	/ month
5	Units	=	$20,000	$10.80	/ month

Legislators/Constitutional Officers Dependent Life Rates

1	Unit	=	$20,000	$10.80	/ month
2	Units	=	$40,000	$21.60	/ month

Retiree Coverage

While actively employed, Basic Group Life and AD&D coverage is paid by the State. Upon retirement, employees must pay the premium of $5.60 a month for the plan to remain in place. Employees who retire with Basic Group Life coverage will have $10,000 Life/AD&D until age 65.

Reductions of Coverage

At age 65 Basic Group Life and AD&D this coverage will reduce to $5,000 and at age 70, it will reduce to $4,000.

The Supplemental Life/AD&D will reduce in half at age 65 and will reduce in half again at age 70. The maximum amount of coverage may not exceed $20,000 for Basic and Supplemental Life combined after age 70. These changes will occur the first of the month following the retiree's birthday.

Dependent Life reduces to 50% at the retiree's age 65, and will reduce in half again at the retiree's age 70.

Note: Accidental Death and Dismemberment (AD&D) benefits terminate at age 75.

For questions regarding your coverage or for claims, please call USAble Life directly at 1-800-370-5854.

Cost Comparisons for

	Medical	Behavioral/EAP	Prescription Drug	Total Monthly Health Premium
Employee Only				
BCBS PPO	$300.10	$5.70	$51.20	$357.00
QualChoice POS	$212.90	$5.70	$51.20	$269.80
Health Advantage POS	$216.70	$5.70	$51.20	$273.60
Health Advantage HMO	$209.20	$5.70	$51.20	$266.10
QualChoice HMO	$196.50	$5.70	$51.20	$253.40
Employee & Spouse				
BCBS PPO	$600.10	$11.40	$102.40	$713.90
QualChoice POS	$425.70	$11.40	$102.40	$539.50
Health Advantage POS	$433.40	$11.40	$102.40	$547.20
Health Advantage HMO	$418.40	$11.40	$102.40	$532.20
QualChoice HMO	$393.10	$11.40	$102.40	$506.90
Employee & Child(ren)				
BCBS PPO	$480.10	$9.10	$76.80	$566.00
QualChoice POS	$340.60	$9.10	$76.80	$426.50
Health Advantage POS	$346.70	$9.10	$76.80	$432.60
Health Advantage HMO	$334.70	$9.10	$76.80	$420.60
QualChoice HMO	$314.40	$9.10	$76.80	$400.30
Employee & Family				
BCBS PPO	$990.20	$18.80	$133.10	$1,142.10
QualChoice POS	$702.50	$18.80	$133.10	$854.40
Health Advantage POS	$715.00	$18.80	$133.10	$866.90
Health Advantage HMO	$690.40	$18.80	$133.10	$842.30
QualChoice HMO	$648.60	$18.80	$133.10	$800.50

Active Employees

Less State Contribution	Total Monthly Health Employee Cost	24thly Health Cost to Employee	Total Monthly Health & Life Employee Cost	24thly Health & Life Cost to Employee
($192.20)	$164.80	$82.40	$164.80	$82.40
($192.20)	$77.60	$38.80	$77.60	$38.80
($192.20)	$81.40	$40.70	$81.40	$40.70
($192.20)	$73.90	$36.95	$73.90	$36.95
($192.20)	$61.20	$30.60	$61.20	$30.60
($295.30)	$418.60	$209.30	$418.60	$209.30
($295.30)	$244.20	$122.10	$244.20	$122.10
($295.30)	$251.90	$125.95	$251.90	$125.95
($295.30)	$236.90	$118.45	$236.90	$118.45
($295.30)	$211.60	$105.80	$211.60	$105.80
($269.00)	$297.00	$148.50	$297.00	$148.50
($269.00)	$157.50	$78.75	$157.50	$78.75
($269.00)	$163.60	$81.80	$163.60	$81.80
($269.00)	$151.60	$75.80	$151.60	$75.80
($269.00)	$131.30	$65.65	$131.30	$65.65
($581.60)	$560.50	$280.25	$560.50	$280.25
($581.60)	$272.80	$136.40	$272.80	$136.40
($581.60)	$285.30	$142.65	$285.30	$142.65
($581.60)	$260.70	$130.35	$260.70	$130.35
($581.60)	$218.90	$109.45	$218.90	$109.45

Cost Comparisons for

	Medical	Behavioral/EAP
Employee Medicare Only		
BCBS PPO	$120.00	$3.90
QualChoice POS	$85.10	$3.90
Health Advantage POS	$84.10	$3.90
Health Advantage HMO	$81.20	$3.90
QualChoice HMO	$78.60	$3.90
Employee Medicare & Spouse		
BCBS PPO	$570.10	$7.70
QualChoice POS	$404.40	$7.70
Health Advantage POS	$399.60	$7.70
Health Advantage HMO	$385.90	$7.70
QualChoice HMO	$373.40	$7.70
Employee Medicare & Child(ren)		
BCBS PPO	$210.00	$6.20
QualChoice POS	$149.00	$6.20
Health Advantage POS	$147.30	$6.20
Health Advantage HMO	$142.20	$6.20
QualChoice HMO	$137.60	$6.20
Employee Medicare & Spouse & Child(ren)		
BCBS PPO	$660.10	$12.80
QualChoice POS	$468.30	$12.80
Health Advantage POS	$462.80	$12.80
Health Advantage HMO	$446.80	$12.80
QualChoice HMO	$432.30	$12.80
Employee Medicare & Spouse Medicare		
BCBS PPO	$240.00	$7.70
QualChoice POS	$170.30	$7.70
Health Advantage POS	$168.30	$7.70
Health Advantage HMO	$162.50	$7.70
QualChoice HMO	$157.20	$7.70
Employee Medicare & Spouse Medicare & Child(ren)		
BCBS PPO	$345.10	$12.80
QualChoice POS	$244.80	$12.80
Health Advantage POS	$241.90	$12.80
Health Advantage HMO	$233.60	$12.80
QualChoice HMO	$226.00	$12.80

Medicare Primary

Prescription Drug	Total Monthly Premium	Retirement Subsidy	Total Monthly Employee Cost
$69.70	$193.60	($54.90)	$138.70
$69.70	$158.70	($54.90)	$103.80
$69.70	$157.70	($54.90)	$102.80
$69.70	$154.80	($54.90)	$99.90
$69.70	$152.20	($54.90)	$97.30
$139.30	$717.10	($191.40)	$525.70
$139.30	$551.40	($191.40)	$360.00
$139.30	$546.60	($191.40)	$355.20
$139.30	$532.90	($191.40)	$341.50
$139.30	$520.40	($191.40)	$329.00
$90.10	$306.30	($112.70)	$193.60
$90.10	$245.30	($112.70)	$132.60
$90.10	$243.60	($112.70)	$130.90
$90.10	$238.50	($112.70)	$125.80
$90.10	$233.90	($112.70)	$121.20
$163.90	$836.80	($217.50)	$619.30
$163.90	$645.00	($217.50)	$427.50
$163.90	$639.50	($217.50)	$422.00
$163.90	$623.50	($217.50)	$406.00
$163.90	$609.00	($217.50)	$391.50
$139.30	$387.00	($106.30)	$280.70
$139.30	$317.30	($106.30)	$211.00
$139.30	$315.30	($106.30)	$209.00
$139.30	$309.50	($106.30)	$203.20
$139.30	$304.20	($106.30)	$197.90
$163.90	$521.80	($174.10)	$347.70
$163.90	$421.50	($174.10)	$247.40
$163.90	$418.60	($174.10)	$244.50
$163.90	$410.30	($174.10)	$236.20
$163.90	$402.70	($174.10)	$228.60

Cost Comparisons for Retirees Not

	Medical	Behavioral/EAP
Employee Only		
BCBS PPO	$450.10	$3.90
QualChoice POS	$319.30	$3.90
Health Advantage POS	$315.60	$3.90
Health Advantage HMO	$304.70	$3.90
QualChoice HMO	$294.80	$3.90
Employee & Spouse		
BCBS PPO	$900.20	$7.70
QualChoice POS	$638.60	$7.70
Health Advantage POS	$631.10	$7.70
Health Advantage HMO	$609.30	$7.70
QualChoice HMO	$598.60	$6.20
Employee & Child(ren)		
BCBS PPO	$720.20	$6.20
QualChoice POS	$510.90	$6.20
Health Advantage POS	$504.90	$6.20
Health Advantage HMO	$487.50	$6.20
QualChoice HMO	$471.70	$6.20
Employee & Spouse & Child(ren)		
BCBS PPO	$1,350.20	$12.20
QualChoice POS	$957.90	$12.20
Health Advantage POS	$946.60	$12.20
Health Advantage HMO	$914.00	$12.20
QualChoice HMO	$884.40	$12.20

Medicare Eligible

Prescription Drug	Total Monthly Premium	State Contribution	Total Monthly Employee Cost
$69.70	$523.70	($176.10)	$347.60
$69.70	$523.70	($176.10)	$216.80
$69.70	$523.70	($176.10)	$213.10
$69.70	$523.70	($176.10)	$202.20
$69.70	$523.70	($176.10)	$192.30
$139.30	$1,047.20	($310.40)	$736.80
$139.30	$785.60	($310.40)	$475.20
$139.30	$778.10	($310.40)	$467.70
$139.30	$756.30	($310.40)	$445.90
$139.30	$736.60	($310.40)	$426.20
$90.10	$816.50	($268.10)	$548.40
$90.10	$607.20	($268.10)	$339.10
$90.10	$601.20	($268.10)	$333.10
$90.10	$583.80	($268.10)	$315.70
$90.10	$568.00	($268.10)	$299.90
$163.90	$1,526.90	($482.40)	$1,044.50
$163.90	$1,134.60	($482.40)	$652.20
$163.90	$1,123.30	($482.40)	$640.90
$163.90	$1,090.70	($482.40)	$608.30
$163.90	$1,061.10	($482.40)	$578.70

Cost Comparison for COBRA Participant

This chart shows your monthly cost.

	Medical	Behavioral /Prescription EAP	Drug	COBRA Admin Fee	Total Monthly Premium
Employee Only					
BCBS PPO	$300.10	$5.70	$51.20	$7.10	$364.10
QualChoice POS	$212.90	$5.70	$51.20	$5.40	$275.20
Health Advantage POS	$216.70	$5.70	$51.20	$5.50	$279.10
Health Advantage HMO	$209.20	$5.70	$51.20	$5.30	$271.40
QualChoice HMO	$196.50	$5.70	$51.20	$5.10	$258.50
Employee & Spouse					
BCBS PPO	$600.10	$11.40	$102.40	$14.30	$728.20
QualChoice POS	$425.70	$11.40	$102.40	$10.80	$550.30
Health Advantage POS	$433.40	$11.40	$102.40	$10.90	$558.10
Health Advantage HMO	$418.40	$11.40	$102.40	$10.60	$542.80
QualChoice HMO	$393.10	$11.40	$102.40	$10.10	$517.00
Employee & Child(ren)					
BCBS PPO	$480.10	$9.10	$76.80	$11.30	$577.30
QualChoice POS	$340.60	$9.10	$76.80	$8.50	$435.00
Health Advantage POS	$346.70	$9.10	$76.80	$8.70	$558.10
Health Advantage HMO	$334.70	$9.10	$76.80	$8.40	$542.80
QualChoice HMO	$314.40	$9.10	$76.80	$8.00	$517.00
Employee & Family					
BCBS PPO	$990.20	$18.80	$133.10	$22.80	$1,164.90
QualChoice POS	$702.50	$18.80	$133.10	$17.10	$871.50
Health Advantage POS	$715.00	$18.80	$133.10	$17.30	$884.20
Health Advantage HMO	$690.40	$18.80	$133.10	$16.80	$859.10
QualChoice HMO	$648.60	$18.80	$133.10	$16.00	$816.50

Health Care At A Glance

Important Note: The only out-of-network services covered under the pure HMO plans are emergency services and insurance company authorized referrals. The Point of Service (POS) out-of-network reimbursement of the health plan to the provider is 70% of the health plan's approved charges, not of the provider or facility's billed charges.

Note: There are no benefit or plan changes for 2003.

PLAN HIGHLIGHT 2002-2003	PPO PLAN* IN NETWORK	PPO PLAN* OUT-OF NETWORK	HMO & POS PLAN* HMO & POS IN NETWORK	HMO & POS PLAN* POS OUT-OF NETWORK
Deductible (First dollar out-of-pocket per plan year)	$500 per person $1,000 per family	$750 per person $1,500 per family	$0 $0	$500 per person $1,000 per family
Coinsurance/ Copayment	20% after deductible	30% after deductible	Per office visit: $20 PCP $25 Specialist	30% after deductible of maximum allowable amount
Out-of-Pocket Limit (after deductible/ copays)	$2,000 per person $4,000 per family	$2,500 per person $5,000 per family	$1,000 per person $1,500 per family	$4,000 per person $8,000 per family
Physician Services	20% coinsurance	30% coinsurance	Per office visit: $20 PCP $25 Specialist $00	30% coinsurance of maximum allowable amount
Inpatient Physicians Services	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Outpatient Physicians Services	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Outpatient Services	20% coinsurance	30% coinsurance	$100 after $100 copay for Outpatient Surgical facility	30% coinsurance of maximum allowable amount

PLAN HIGHLIGHT 2002-2003	PPO PLAN* IN NETWORK	PPO PLAN* OUT-OF NETWORK	HMO & POS PLAN* HMO & POS IN NETWORK	HMO & POS PLAN* POS OUT-OF NETWORK
Diagnostic Testing (Lab and X-ray)	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Ambulance $1,000 annual limit	20% coinsurance	30% coinsurance	0% coinsurance	30% coinsurance
Inpatient Hospital	20% coinsurance	30% coinsurance	$250 copay plus 10% coinsurance per admission with maximum 3 copays per member per year	30% coinsurance of maximum allowable amount
Preventive Care	Not covered except well-baby and GYN visits 20% coinsurance	Not covered except well-baby and GYN visits 30% coinsurance	Covered $20 PCP $25 Specialist	Not covered except well-baby and GYN visits 30% coinsurance
Mental Health / Substance Care/Physician Inpatient & Outpatient	All in and out of network mental health and substance abuse services must be pre-authorized by CORPHEALTH. Call CORPHEALTH at 1-866-378-1645. (See next section for specific details)			
Preventative and Diagnostic Dental Care	Not covered	Not covered	$25 copay 1 visit every 6 months	Not covered
Home Health Nursing Visits 120 annual visits	20% coinsurance	30% coinsurance	0%	30% coinsurance

PLAN HIGHLIGHT 2002-2003	IN NETWORK	OUT-OF NETWORK	HMO & POS IN NETWORK	POS OUT-OF NETWORK
Home Infusion IV drugs and Solutions	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Routine Vision	Not covered	Not covered	$25 copay 1 visit every 24 months	Not covered
Emergency Care	20% coinsurance	20% coinsurance	$100 copay waived if admitted to same hospital	$100 copay copay waived if admitted to hospital
Transplants	Must be approved by plan, then 20% coinsurance	Must be approved by plan, then 30% coinsurance	Must be approved by plan, then $250 copay	Not covered
Durable Medical Equipment Annual Maximum $10,000	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
DME Repairs	Must be approved by plan	Must be approved by plan	Must be approved by plan	Must be approved by plan
Physical, Occupational, and Speech Therapy Chiropractic Services and Cardiac Rehabilitation	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
	(Limited to 60 combined visits per member per year)			
	PPO PLAN*		**HMO & POS PLAN***	

PLAN HIGHLIGHT 2002-2003	IN NETWORK	OUT-OF NETWORK	HMO & POS IN NETWORK	POS OUT-OF NETWORK
Allergies	20% coinsurance	30% coinsurance	$20 copay PCP $25 copay specialist	30% coinsurance
Maternity Benefits	*Physician* 20% coinsurance	*Physician* 30% coinsurance	*Physician* 10% coinsurance, copay for initial office visit	*Physician* 30% coinsurance
	Hospital 20% coinsurance	*Hospital* 30% coinsurance	*Hospital* $250 copay per admission plus 10% coinsurance;	*Hospital* 30% coinsurance
Maximum Benefits	No Maximum	$1,000,000	No Maximum	$1,000,000

- Out-of-network benefits apply when you do not visit your Primary Care Physician or follow the plan's referral procedures when visiting a specialist or hospital. For more specific information about a plan's referral process, contact the plans at the numbers listed on Contacts page.
- Two family members must meet the individual deductible or out-of-pocket limit to satisfy the family deductible or out-of-pocket limit.
- All medical coinsurance applies to the physical health out-of-pocket maximum.

Mental and Behavioral Health Benefits

CorpHealth coordinates ALL behavioral health care for Arkansas State Health Care enrollees. Your benefit program and network of mental healthcare providers is completely separate from your medical, no matter which medical plan you select. Mental Health and Substance Abuse and a new Employee Assistance Program (EAP) are included in the Behavioral Health Care Benefit.

You must access your behavioral health care benefit by calling the Arkansas Help-line toll-free at 1-866-378-1645. All mental health, behavioral health and substance abuse services must be pre-authorized by CorpHealth or the claims will be denied

The benefits include an Employee Assistance Program (EAP) and a mental health, behavioral health and chemical dependency benefit. The program provides enhanced access and benefits in both the EAP and mental health and substance abuse benefit coverage. You do not have to obtain a referral from your Primary Care Physician to seek help from the Employee Assistance Program or to access your mental health or substance abuse benefits. All contact with EAP is strictly confidential.

Access is easy. Simply call the Arkansas Help Line toll-free at 1-866-378-1645 24 hours a day, 365 days a year.

- You'll have immediate access to a professional to help you assess your needs, sort through your options, and find effective resources.
- Telephonic and/or face-to-face sessions with one of the EAP affiliate counselors.
- Pre-certification for mental health and substance abuse treatment.
- Individualized referrals to resources in your community.

The EAP program provides you with short-term assessment and counseling with no copay for you or your covered dependents. The EAP provides immediate access to a clinical assessment and outpatient EAP treatment of up to eight (8) sessions, and/or referral to a behavioral health (mental health or chemical dependency) specialist that is covered under the plan at the benefit schedule summarized on the next page:

The EAP benefits include a complete range of services such as:

Emotional Well-Being

- Personal relationships
- Marriage and family issues
- Divorce and separation
- Coping with violence
- Grief and loss

Addiction and Recovery Assessments & Referrals to Specialists

- Alcohol and drugs
- Gambling
- Other addictions
- Support groups
- Eating disorders

Parenting

- Single parenting and blended families
- Discipline, setting limits and safety
- Child development

Work

- Work and personnel issues
- Adjusting to change in the workplace
- Stress management

Financial

- Budgeting
- Managing credit and collections problems

Legal

- Referral to community resources

Key Things to Remember:

- Always access the benefit by first calling the Arkansas Help Line, 1-866-378-1645.

- **All services require pre-authorization or no benefits will be paid.**

- Information about providers and benefits is available at www.CorpHealth.com. There will be no benefit for non-CORPHEALTH network providers where the care is not directed by CORPHEALTH, Inc. or is not an emergency.
- Always obtain a referral authorization from your CORPHEALTH case manager by calling the Arkansas Help Line at 1-866-378-1645.
- Refer to the Behavioral Health Care At A Glance below:

	Benefit Description	In-Network	Out-of-Network
I.	Employee Assistance Program (EAP) Telephonic Consultation and Face-to-Face Short Term/Brief Issue Resolution Counseling	Up to eight (8) EAP sessions per episode with no copayment. Must call Arkansas Help Line at 1-866-378-1645.	Not covered
II.	Initial Behavioral Health Benefit	Must call Arkansas Help Line at 1-866-378-1645.	Not covered
Deductible:		$0 Individual $0 Family	$0 Individual $0 Family
	Copayment for Traditional Out-Patient Services	$25 copay/ office visit	$25 copay + 25% coinsurance
	Out-of-Pocket Maximum (After copays and deductibles)	$1,000 Individual $1,500 Family	$1250 Individual $1875 Family
	Out-Patient Services (Partial hospital / day treatment)	No copay	25% coinsurance
	Out-Patient Services (Intensive Outpatient)	No copay	25% coinsurance
	Residential Treatment	10% Coinsurance	35% coinsurance
	In-Patient Services	$250 Copay + 10% coinsurance per admission	35% coinsurance/admit

Visit the CORPHEALTH web site at

www.corphealth.com

All mental health or substance abuse services, must be preauthorized by CORPHEALTH prior to receiving care.

All mental health and substance abuse claims for care rendered must be submitted to:

Claims Department
CORPHEALTH, Inc.
1701 Centerview Dr., Suite 101 Little Rock, AR 72211

Inpatient

You must call CORPHEALTH at 1-866-378-1645 to pre-certify any care that may be necessary.

Please contact the Arkansas Help Line toll-free at 1-866-378-1645 (7 days a week, 24 hours a day) if you have additional questions.

Questions & Answers

ACTIVE EMPLOYEES

Q1: If I am an eligible active employee not currently participating in the Health Insurance Program, may I enroll now?

A: Yes. If you want health insurance coverage this year, you must enroll during this enrollment period. Unless you or your dependents qualify under the following federal laws, you cannot enroll outside of the open enrollment period. The following are examples of circumstances that would allow a mid-year change to insurance coverage:

- You or your eligible dependents have lost other health insurance coverage through no action of your own.
- You have acquired a new eligible dependent through marriage, birth, adoption or placement for adoption.

Note: Voluntary termination from another plan does not qualify you to enroll in this plan. Enrollment would be delayed until the annual Open Enrollment period.

Q2: Do I have to complete a new enrollment form this year?

A: Not if you want to remain in your current health insurance plan.

Q3: What if I want to change my health insurance plan?

A: Submit your completed enrollment form to your agency insurance representative by the date they specify in late October. For members of the POS and HMO plans, new referrals must be obtained when changing from one insurance carrier to another.

Q4: If I change to a new plan during enrollment, will I be subject to a pre-existing condition limitation?

A: The pre-existing condition period has been removed by all carriers.

Q5: Are the network providers in my current plan remaining the same?

A: There are frequent changes in every network; therefore, please check the provider directories or – for the latest network information – call the plans or visit their web sites. See Contacts for telephone numbers and available web site addresses.)

Q6: Do I have to select the same Primary Care Physician for my entire family?

A: No. Each member of your family may select a different Primary Care Physician. QualChoice requires their female members over the age of sixteen (16) to select two (2) Primary Care Physician's. One for physical health and one for gynecological care. Family Practice and Internal Medicine physicians can be both physical health and gynecological Primary Care Physician.

Q7: May I change my Primary Care Physician at any time?

A: Yes, but because each plan has its own guidelines, you should contact the POS or HMO plan in which you are enrolled.

Q8: What is the difference between a "Pure HMO" and the POS plans offered?

A: A pure HMO offers no out-of-network benefits except in cases of dire emergency or special insurance company pre-authorized out-of-network referrals. An HMO requires a member to obtain a referral from their PCP. If referrals are not obtained from the Primary Care Physician the claim will be denied. POS plans offer an HMO benefit when an insured stays in network with a Primary Care Physician referral, but also offers reduced benefits when the insured seeks specialty services without a referral.

The POS benefit allows you to go out-of-network, just remember that 70% of maximum allowable payment is not 70% of billed charges. The POS benefit can be used for members who reside out of state also, because you can use providers that are not in the network. The HMO plan is not designed for members who live out of state, as there are no benefits outside the network. Most networks are only statewide. There are a few exceptions to that rule if you reside in a border city such as Texarkana, West Memphis, etc. Please contact your specific HMO carrier to determine if networks are available to you in the border cities.

Q9: What is a PPO and how does a PPO differ from an HMO and POS?

A: A PPO is an Indemnity Plan. In a PPO Plan, a member has a separate deductible and a separate coinsurance for both in and out of network services. The PPO plan gives you the most flexibility in selection providers and hospitals. It is also the most expensive benefit option. The HMO and POS plans have a more limited network and less flexibility. The POS plans allow you to access care out-of-network, without a Primary Care Physician referral, however, the cost is greater that the HMO plans. HMO plans require you to access all medical care through a Primary Care Physician referral

Q10: Are my child's immunizations a covered benefit?

A: State mandated immunizations are a covered benefit for children up to age 18. Some adult immunizations qualify as a covered benefit. Contact your insurance plan if you have questions about immunizations.

Q11: How can my children who are away at college in-state access my POS or HMO Plan?

A: Routine non-emergency medical services are paid according to "in" and "out-of-network" rules. A network provider located in the college town qualifies as "in-network," just like a home-town in-network physician. We recommend your child select a Primary Care Physician in the college town. Emergency services, regardless of the provider used, are paid "in-network". Charges incurred at a school infirmary are not covered.

Q12: How can my children who are away at college out-of-state access my POS or HMO Plan?

A: Routine healthcare benefits for college students out-of-state will be limited or non-existent and the HMO would be the least favored plan for out-of-state college students. Health care benefits are available in the POS plan just remember that the POS benefit reimburses at 70% of maximum allowable amount rather than 70% of billed charges after the deductible is met. Therefore, for a college student out of state, this plan does provide some limited benefits. Call your health insurance carrier to inquire if a guest membership is available for out of state students. The PPO plan is the best plan to have for out-of-state college students.

Q13: If my Primary Care Physician pulls out of the network that I am enrolled in after the enrollment period, may I change plans?

A: Plan changes mid-year are rarely allowed. Only in cases of documented lack of access to providers will a mid-year enrollment be permitted. For example, in the event that a county loses all of its network providers in a particular plan, a "special" re-enrollment would permit all plan participants in that county to select another plan.

Q14: How do I enroll in the Supplemental Life program offered by USAble Life?

A: New employees will have 30 days from their hire date to enroll in the Supplemental Life program without evidence of insurability. You may apply for Supplemental Life even if you are not enrolled in the Health Plan. If you are currently insured by the State Employee group health plans, but have not elected Supplemental Life, you may make application by providing evidence of insurability. If you are not enrolled in the State Employee group health plan and wish to enroll in the Supplemental Life Plan you may make application by providing evidence of insurability. Please contact your Agency Insurance Representative to obtain a Supplemental Life application.

Q15: How much Supplemental Life may I apply for?

A: You may apply for either one or two times your annual salary (coverage may not exceed $250,000; for Legislators/Constitutional Officers, coverages may not exceed $50,000).

Q16: Are diabetic supplies covered?

A: Yes. Diabetic supplies are covered through AdvancePCS, Inc. Glucometers are covered by your health carrier.

RETIRED EMPLOYEES

Q1: Can retirees who dropped coverage in the past come back on the plan during the enrollment period?

A: No. Coverage dropped by retirees cannot be reinstated unless they lose eligibility for coverage under another health plan.

Q2: Do retirees who wish to remain in the same plan need to complete a form this year?

A: No.

Q3:What if I want to change my health insurance plan?

A: Submit your completed form to the Employee Benefits Division with a postmark no later than October 31, 2002.

Q4: May I change my insurance plan if I retire after October 31, 2002?

A: Plan changes can be made only at "open enrollment" unless you have a life changing event that qualifies you for a "special enrollment".

Q5: What if I select COBRA rather than the retirement plan?

A: If you select COBRA you must stay on COBRA your entire eligibility period to qualify for insurance through the Retirement Program. COBRA participants lose the life insurance benefit. This benefit will not be reinstated when you go to the retirement group. Your COBRA carrier will bill you monthly. If your COBRA benefits are terminated for non-payment or late-payment, you will not be eligible for insurance through the retirement program.

Q6: How will my retirement premiums be billed?

A: Your premium will be automatically deducted from your retirement check every month. If your retirement check is not large enough for a premium deduction EBD can draft your bank account or you will be provided with a coupon booklet for making monthly payments.

Q7: What if I have Medicare?

A: If you are retired and have Medicare, Medicare is your primary insurance coverage. You must have both Part A & B Medicare. If you do not have Part B the health plan will pay as if you have Part B. The State insurance plan is secondary to Medicare.

If you have Medicare and are an active state employee (working) your State plan is your primary insurance coverage and Medicare is your secondary insurance coverage. Also, please remember that Medicare coverage is very limited. Your State prescription drug program will cover most of your prescription drugs.

COBRA PARTICIPANTS

Q1: May I change plans if I go on COBRA?

A: COBRA participants are eligible to change plans at "open enrollment." You cannot change plans in mid-year.

Q2: Are the same benefits offered to COBRA participants as to active employees?

A: COBRA participants have the same pharmacy and medical benefits as active and retired employees. Life insurance is not available to COBRA participants, through this health plan. Contact USAble Life for conversion options.

CORPHEALTH/STAREAP

Q1. What is the difference between the EAP and Managed Care benefit?

A: StarEAP is designed to help you resolve short-term problems related to work, relationships, parenting, finances, school, elder care, etc. There is no copay required.

Managed Care is designed to address medically diagnosed mental health problems which require treatment for a period of 3 months or more. Treatment can include medication, psychiatric/psychological evaluation, individual, group or family therapy. You receive unlimited sessions, as long as they are medically necessary. There is a copay.

Q2. Do I have a choice of providers?

A: Yes. There are licensed clinicians (master's level, doctorate level and MDs) throughout the state and you can go to any provider in the CorpHealth network, statewide. You can call CorpHealth directly or go to their website www.corp health.com for a current list of providers.

If you require medical care for a mental health problem, you must use a hospital that is in your medical plan's network. (Example: If you are covered by Health Advantage you should verify that the hospital is in the Health Advantage network. You can do this by contacting Health Advantage).

Q3. Is my family eligible for mental health benefits?

A: State employees are eligible for StarEAP benefits even if they are not enrolled in a State health insurance plan. Family members can participate in couple or family sessions with the employee. Enrollees in a State health insurance plan and their enrolled dependents are eligible for StarEAP and managed care benefits through CorpHealth.

Q4. Will my employer know if I use StarEAP?

A: Your use of the EAP benefit is strictly confidential. In order for information about your participation in the EAP to be released to anyone, you must sign an authorization to release information. Employers can refer you to the EAP if they feel it can be of help to you, if they are concerned about

your work performance or if you have a drug free work policy and test positive for a drug screen. Employer referrals to the EAP may require your participation in the EAP, but again, you must sign a release in order for your information to be shared with your employer.

EBD

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